

# The side effects developed upon anti-COVID-19 vaccination and their association with the infection with SARS-CoV-2

Study name: The side effects developed upon anti-COVID-19 vaccination and their association with the infection with SARS-CoV-2.

Participant information: We are inviting you to participate in our questionnaire which will take less than 10 minutes. This questionnaire is for a study performed on adults in Oman only by researchers in the Department of Microbiology and Immunology in the College of Medicine and Health Sciences in the Sultan Qaboos University (SQU). This study was approved by the Medical Research Ethics Committee in the college (MREC#2784) and the National Center for Statistics and Information (NCSI# 224215459). Please read the following information about the study before you participate. The aim of this study is to assess the association of the side effects of different anti-SARS-CoV-2 (COVID-19) vaccines with different parameters including previous infection(s) with SARS-CoV-2. The questionnaire is anonymous. There are no questions that can reveal your identity. You are free to withdraw from the study at any time. The results of the study will be presented in scientific journals and/or conferences. For any queries, please contact the principal investigator Dr. Elias Said ([esaid@squ.edu.om](mailto:esaid@squ.edu.om)). We thank you for reading this and your participation.

Informed Consent for research participation: I confirm and attest that I have read and understood the participant information sheet and I appreciate that participation is voluntary and I am free to withdraw from the project at any time to the time of completion. I understand that the anonymized data cannot be withdrawn once included in this study and any recorded information will remain confidential. I am adult and I freely give my consent to participate in this research study.

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\* Required

1. Do you agree to participate in the study? \*

*Mark only one oval.*

Yes

No

2. 1. Sex: \*

*Mark only one oval.*

Female

Male

3. 2. Nationality: \*

*Mark only one oval.*

Omani

Non-Omani

4. Please specify your nationality if you answered "Non-Omani"

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5. 3. Country of residence: \*

*Mark only one oval.*

Oman

Other: \_\_\_\_\_

6. 4. What is your age (years)? \*

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7. 5. What is your weight (Kg)? \*

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8. 6. What is your height (cm)? \*

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9. 7. Occupation: \*

*Mark only one oval.*

None

Yes

10. Please specify your occupation if you answered "Yes"

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11. 8. Level of Education: \*

*Mark only one oval.*

School

Diploma degree

Bachelor's degree

Master's degree

Doctorate degree

Other

12. Please specify your education level if you answered "Other"

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13. 9. Do you have any Allergy? \*

*Mark only one oval.*

No

Yes

14. Please specify your allergy(ies) if you answered "Yes"

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15. 10. Do you have any chronic disease? \*

*Check all that apply.*

- No
- Diabetes type 1
- Diabetes type 2
- Hypertension
- Other: \_\_\_\_\_

16. 11. Do you have any autoimmune disease? \*

*Mark only one oval.*

- No
- Yes

17. Please specify your autoimmune disease if you answered "Yes"

\_\_\_\_\_

18. 12. Do you routinely take any drugs (including Anti-inflammatory, Vitamins and Supplements, etc.)? \*

*Mark only one oval.*

- No
- Yes

19. Please specify the drugs if you answered "Yes"

\_\_\_\_\_

20. 13. How many anti-SARS-CoV-2 (corona virus) vaccine doses did you get? \*

*Mark only one oval.*

- 1
- 2
- 3
- More
- Not applicable

21. Please specify the number of doses if you answered "More"

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22. 14. Type of vaccine in the first dose \*

*Mark only one oval.*

- Pfizer-BioNTech
- Moderna
- Astra-Zeneca Oxford
- Janssen
- Sputnik V
- Sinopharm
- Sinovac
- Other
- I do not know
- Not applicable

23. Please specify the type of vaccine in the first dose if you answered "Other"

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24. 15. Type of vaccine in the second dose \*

*Mark only one oval.*

- Pfizer-BioNTech
- Moderna
- Astra-Zeneca Oxford
- Janssen
- Sputnik V
- Sinopharm
- Sinovac
- Other
- I do not know
- Not applicable

25. Please specify the type of vaccine in the second dose if you answered "Other"

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26. 16. Type of vaccine in the third dose \*

*Mark only one oval.*

- Pfizer-BioNTech
- Moderna
- Astra-Zeneca Oxford
- Janssen
- Sputnik V
- Sinopharm
- Sinovac
- Other
- I do not know
- Not applicable

27. Please specify the type of vaccine in the third dose if you answered "Other"

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28. 17. The period between the first and second dose (weeks) \*

*Mark only one oval.*

1

2

3

4

5

6

7

8

9

10

11

12

Other

Not applicable

29. Please specify the period between the first and second dose if you answered "Other"

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30. 18. The period between the second and third dose (weeks) \*

*Mark only one oval.*

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- Not applicable

31. Please specify the period between the second and third dose if you answered "Other"

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## 32. 19. Side effects after the first dose? \*

*Check all that apply.*

- None
- Fever less than 38°C
- Fever 38-39°C
- Fever 39-40°C
- Fever higher than 40°C
- Local pain at the site of injection
- Dizziness
- Fatigue
- Chills
- Body ache
- Swollen lymph nodes
- Headache
- Allergy
- Numbness
- Thrombosis
- Myocarditis
- Diarrhea
- Stomachache
- Flu-like symptoms
- Fast heartbeat
- Difficulty in breathing
- Bell's palsy
- Tenderness
- Not applicable
- Other: \_\_\_\_\_

## 33. 20. Side effects after the second dose? \*

*Check all that apply.*

- None
- Fever less than 38°C
- Fever 38-39°C
- Fever 39-40°C
- Fever higher than 40°C
- Local pain at the site of injection
- Dizziness
- Fatigue
- Chills
- Body ache
- Swollen lymph nodes
- Headache
- Allergy
- Numbness
- Thrombosis
- Myocarditis
- Diarrhea
- Stomachache
- Flu-like symptoms
- Fast heartbeat
- Difficulty in breathing
- Bell's palsy
- Tenderness
- Not applicable
- Other: \_\_\_\_\_

## 34. 21. Side effects after the third dose? \*

*Check all that apply.*

- None
- Fever less than 38°C
- Fever 38-39°C
- Fever 39-40°C
- Fever higher than 40°C
- Local pain at the site of injection
- Dizziness
- Fatigue
- Chills
- Body ache
- Swollen lymph nodes
- Headache
- Allergy
- Numbness
- Thrombosis
- Myocarditis
- Diarrhea
- Stomachache
- Flu-like symptoms
- Fast heartbeat
- Difficulty in breathing
- Bell's palsy
- Tenderness
- Not applicable
- Other: \_\_\_\_\_

35. 22. When did the symptoms appear after the \*

*Check all that apply.*

	Not applicable	Within a few minutes	Within a few hours	After 1 day	After 2 days	After 3-7 days	Other
<b>first dose?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>second dose?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>third dose?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. Please specify if you answered "other" after the first dose

\_\_\_\_\_

37. Please specify if you answered "other" after the second dose

\_\_\_\_\_

38. Please specify if you answered "other" after the third dose

\_\_\_\_\_

39. 23. How long did the symptoms last after the \*

*Check all that apply.*

	Not applicable	Minutes	Hours	1 day	2 days	3-7 days	Other
<b>first dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>second dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>third dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Please specify if you answered "other" after the first dose

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41. Please specify if you answered "other" after the second dose

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42. Please specify if you answered "other" after the third dose

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43. 24. Did you take any medications to treat the side effects \*

*Check all that apply.*

	None	Paracetamol (Acetaminophen, Panadol, Doliprane, Adol, etc.)	Ibuprofen (Advil, Brufen, etc.)	Aspirin	Prednisone	Prednisolone
<b>First dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Second dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Third dose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. 25. If you had allergy, thrombosis and/or myocarditis as side effects how was it confirmed and associate with the vaccine? \*

*Mark only one oval.*

- Not applicable
- Self-assessment
- Medical consultation

45. 26. Were you infected with SARS-CoV-2 (COVID-19)? \*

*Mark only one oval.*

Yes

No

46. 27. How many times did you have COVID-19? \*

*Mark only one oval.*

Unkown

None

1

2

Other: \_\_\_\_\_

47. 28. Do you remember the months and years of the infections? \*

*Mark only one oval.*

Not applicable

No

Yes

48. Please specify for the first infection if you answered "Yes"

\_\_\_\_\_  
*Example: January 7, 2019*

49. Please specify for the second infection if you answered "Yes" (Do not fill if not applicable)

\_\_\_\_\_  
*Example: January 7, 2019*

50. Please specify for the third infection if you answered "Yes" (Do not fill if not applicable)

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*Example: January 7, 2019*

51. 29. How was the COVID-19 infection confirmed? \*

*Mark only one oval.*

- Not applicable
- PCR
- Rapid (Antigen) test
- Sure of contamination by somebody who had a confirmed COVID-19
- Other: \_\_\_\_\_

52. 30. Did you have COVID-19 before or after anti-SARS-CoV-2 vaccination (you can select more than one option)? \*

*Check all that apply.*

- Not applicable
- Before first dose
- After first dose
- Before second dose
- After second dose
- Before third dose
- After third dose
- Other: \_\_\_\_\_

53. 31. What were the symptoms during the first infection? \*

*Check all that apply.*

	I was not infected	None	Fever less than 38°C	Fever 38-39°C	Fever 39-40°C	Fever higher than 40°C	Cough	Acidosis
<b>first infection</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>second infection</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>third infection</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

54. Please specify the symptom(s) if you answered "Other" for the first infection

\_\_\_\_\_

55. Please specify the symptom(s) if you answered "Other" for the second infection

\_\_\_\_\_

56. Please specify the symptom(s) if you answered "Other" for the third infection

\_\_\_\_\_



57. 32. How long did the symptoms last in each infection? \*

Mark only one oval per row.

	Not applicable	3-7 days	8 days to 2 weeks	3-4 weeks	5-8 weeks	Other
<b>First infection</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Second infection</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Third infection</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. Please specify the length if you answered "Other" for the first infection

\_\_\_\_\_

59. Please specify the length if you answered "Other" for the second infection

\_\_\_\_\_

60. Please specify the length if you answered "Other" for the third infection

\_\_\_\_\_

61. 33. If you did not have COVID-19, did you have any of these symptoms in the past 2 years without performing tests to confirm the origin? \*

*Check all that apply.*

- Not applicable
- None
- Fever less than 38°C
- Fever 38-39°C
- Fever 39-40°C
- Fever higher than 40°C
- Cough
- Acidosis
- Headache
- Diarrhea
- Irritated eyes
- Rash on skin
- Discoloration
- Loss of speech
- Loss of mobility
- Confusion
- Chest pain
- Sore throat
- Runny nose
- Body ache
- Chills
- Fatigue
- Itchy throat
- Hoarse voice
- Loss of smell
- Loss of taste
- Difficulty to breath
- Low O2 levels
- Other: \_\_\_\_\_

62. 34. Did these symptoms (in the previous question) appear before or after anti-SARS-CoV-2 (coronavirus) vaccination (you can select more than one option)? \*

*Check all that apply.*

- Not applicable
- Before first dose
- After first dose
- Before second dose
- After second dose
- Before third dose
- After third dose
- Other: \_\_\_\_\_

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